

~~Redundancy~~ USEMBASSY SEOUL Newcomer Form Check-in

Welcome to Seoul. Like any Post, there are many forms that need to be filled out. Many of these forms are out of our control – i.e. forms required from **DoD** and the **Government of Korea** – which we can not modify to automate.

What we did do, is attempt to take as much of the *redundancy* – i.e. writing your name on ten different forms - out of many of the forms you need to fill out.

Please enter *as much* information on page one and two as you can and send it to HR employee, Ms. Chang, Dong Sook at changds@state.gov ([Click to Send E-mail](#))

We would greatly appreciate it, if during your check-in, if you encounter any forms not included on our system, to get an extra copy and send it to the ISO in room 503.

The Following is the list of forms

1. Check in List from HR section
2. Application for MOFAT ID card.
3. Application for Korean Driver's license
4. Foreign Service Emergency Locator Information
5. Foreign Allowances Application Grant and Report
6. Travel Reimbursement Voucher
7. Leave accounting for American Employees Transferring to Post
8. Direct Deposit Sign-Up Form
9. Command Unique Personnel Information Data System Application
10. 121ST General Hospital CHCS Registration Form
11. Client Medical Profile and Check-in Sheet
12. Department of Defense Education Activity Student Registration – 2 set
13. Department of Defense Education Activity Questionnaire for Race/Ethnicity and home Language
14. Student Eligibility
15. School Health Record – Seoul American Elementary/ Middle/ High School
16. DoDDS Certification of Immunization
17. DoDDS Special needs Questionnaire
18. DoDDS Publicity Permission Form
19. DoDDA Student Computer and Internet access Agreement
20. Box Office Rental Membership Application
21. Korea region MWR CATV – Sales Contract
22. U.S. Embassy Association Members Application

Employee Data

All the Name Field should be entered with **Last, First M** format.
All the Date Field should be entered with **MM/DD/YY** format.

Current Date:

Name :					Gender:				
Social Security Number:					Date of Birth: (MM/DD/YY)				
Place of Birth – City:					State:		Country:		
Legal Residence: City :					State:				
Job Title:					Section:				
Diplomatic Title:									
Agency:					Authorization/Grant No:				
Current Post : Seoul Korea					Previous Post :				
No of dependents with you in ROK:					Personal E-mail:				
Pay Plan:		Series:		Grade:		Step:		Annual Salary:	
Passport Number:					Type: Diplomatic		Date Expires:		
Visa Number:					Type: A1		Date Expires:		
Date of arrival:					Entry on Duty Date:				
Mailing Address in Korea (If you don't know, this will be entered by HR section upon arrival)									
Office Phone No:					Home Phone No:				
Emergency Contact Data (Please provide the emergency contact person's data)									
Name:					Home Phone No:				
Office Phone No:					Relationship:				
Address (Street, city, state, zip code)									
US Driver's License Information									
(Please provide the following information for Korean Driver's License Application)									
License Number:					State of Issue:				
Date of Issue:					Expiration Date:				
Language Skill Information (example: Korean 3+ 3)									
No	Language				Speaking			Reading	
1									
2									
3									
4									
5									
Institution (Please list colleges and graduate schools)									
School Name			Date from		Date to		Degree		Major

Curriculum vitae.

please provide a brief curriculum vitae to be included in the Ministry of Foreign Affairs Identification Card application. The following is an example.

1985	University of California, BA
1989	University of California, MA
1992	Joined the Department of State
1993-1996	US Embassy, Shenyang, Consular officer
1996-1999	US Embassy, Hong Kong, Economic Officer
1999-2002	US Embassy, Japan, Consular Officer

1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Spouse Data

Relationship: Spouse	Name:
Social Security Number:	Date of Birth (MM/DD/YY):
Passport Number:	Type: Diplomatic Date Expires:
Visa Number:	Type: A1 Date Expires:
Place of Birth – City:	State: Country:
Citizenship:	Gender:
Personal E-mail:	
Diplomatic Title:	

US Driver's License Information (Spouse)

(For Korean Driver's License Application for spouse if he/she wants to apply)

License Number:	State of Issue:
Date of Issue:	Expiration Date:

Spouse's Emergency Contact Data

(Please provide emergency contact person's information for spouse)

Name:	Home Phone No:
Office Phone No:	Relationship:
Address (Street, city, state, zip code)	

Children Data		
Relationship: Child 1		Name:
Social Security Number:		Date of Birth (MM/DD/YY):
Gender:		Grade:
Passport Number:		Type: Diplomatic Date Expires:
Visa Number:		Type: A1 Date Expires:
Place of Birth – City:		State: Country:
Citizenship:		
Diplomatic Title:		
Relationship: Child 2		Name:
Social Security Number:		Date of Birth (MM/DD/YY):
Gender:		Grade:
Passport Number:		Type: Diplomatic Date Expires:
Visa Number:		Type: A1 Date Expires:
Place of Birth – City:		State: Country:
Citizenship:		
Relationship: Child 3		Name:
Social Security Number:		Date of Birth (MM/DD/YY):
Gender:		Grade:
Passport Number:		Type: Diplomatic Date Expires:
Visa Number:		Type: A1 Date Expires:
Place of Birth – City:		State: Country:
Citizenship:		
Relationship: Child 4		Name:
Social Security Number:		Date of Birth (MM/DD/YY):
Gender:		Grade:
Passport Number:		Type: Diplomatic Date Expires:
Visa Number:		Type: A1 Date Expires:
Place of Birth – City:		State: Country:
Citizenship:		

If you are sending on OpenNet PC, Outlook will open new message with attachment. Click Send button !
 If you are sending on personal PC, an E-mail program needs to be setup.
 Internet Option → Program → E-mail → choose proper program (Recommend Outlook Express)

How to setup Outlook Express? <http://www.microsoft.com/windows/ie/using/howto/oe/setup.msp>

B. Complete application for Ration Control Plate(s).

Vicki Meredith/OMS

C. Community Liaison Office (Room 406 - Ext. 4398)

Paul Mazeika

III. REGIONAL SECURITY OFFICE (ROOM 402) - Ext. 4161

- A. Arrange for Security Briefing (MANDATORY).
(Employee and Family)
- B. Obtain Pertinent Memoranda and the Security
Precautions Briefing Sheet.
- C. Arrange for Embassy identity cards for yourself
(and dependents over 10 years of age). Photos will be
taken in the Local Security Office (Room 401).

Nelia Hill, RSO

IV. HEALTH UNIT (ROOM 403) - Ext. 4140

- A. Complete patient registration form for each member of the
family for Embassy Health Unit and 121 General Hospital.
- B. Update vaccinations (bring immunization records).
- C. Obtain current Health and Information booklet.
- D. Get health briefing from Embassy
Nurse Practitioner or Nurse.

Nurse Practitioner/Nurse

V. FINANCIAL MANAGEMENT CENTER (ROOM 400) - Ext. 4367

- A. Meet Financial Management Officer

Michael Browning

- B. Receive and complete the following:
 - 1. Travel Voucher Draft
 - 2. Foreign Allowances Application (SF-1190)
 - 3. Electronic Fund Transfer (EFT) Application

Oh, Jungsung

4. Allotment Forms (if necessary)
5. W-4 Forms (withholding Allowance Certificate)
6. Three (3) Months Advance Pay (Overseas Assignments)
7. Education Allowance Application (SF-1190)
8. Post Allowances (COLA) Application (SF-1190)

Son, Su Kyung

VI. INFORMATION MANAGEMENT OFFICE

- A. Information Programs Center (IPC)
(Ext. 4393, 7th Floor, Room 700)

IPO

- B. Radio and Telephone Office (RTO)
(Ext. 4345, 4th Floor, Room 400-H)

- C. Mailroom/APO (Ext. 4595, 1st Floor, Room 102)

- D. IMO Secretary (Ext. 4333, 5th Floor, Room 503C)
Pick up Cellular Phone (State employees only)

- E. Information Systems Center (ISC)
(Ext. 4542, 5th Floor, Room 503-E)

VII. POST LANGUAGE PROGRAM - Only for State Department Employees

Meet Post Language Training Director - Briefing on PLP
(Appointment required/ext. 4706, FSI/Seoul, GSO Compound)

Kwak, Soon

VIII. AMBASSADOR'S OFFICE (ROOM 800) - EXT. 4203

- A. Make appointment to see Ambassador

AMB OMS

- B. Make appointment to see DCM

DCM OMS

IX. GENERAL SERVICES OFFICE (GSO ANNEX NEAR YONGSAN)

GSO/PA check in for newcomers to Embassy Seoul takes place on **Monday mornings** at 8:30. The briefing includes an introduction to GSO key personnel and a chance to discuss your housing, incoming shipments (HHE and UAB),

vehicle importation or purchase procedures, and the home-to-work shuttle.

The GSO/PA compound is located separately from the chancery (near Camp Coiner, adjacent to Yongsan Army Garrison), about 10 minutes from the Housing Compound. To facilitate newcomers' check-in processing with GSO and PA, **GSO/Motor Pool provides a shuttle from the Housing Compound to GSO at 8:15 a.m.** There is another shuttle departing at 9:30 each morning from the GSO/PA compound for the chancery (about a 20 minute drive) and another shuttle at the same time going back to the compound for spouses attending the briefing. Please contact the GSO Secretary at extension 4700 to let us know in advance you will be checking in, if possible.

A. Meet the Supervisory General Services Officer:

SGSO

B. Meet Property Management Officer and Staff:
Discuss furniture/furnishings, Request for Services (KOR-80) Form, and occupant's responsibilities/liabilities for USG-provided property, etc.

Alexei Kral/GSO-PM

C. Meet Facility Management Officer and Staff:
Discuss procedures for Requesting Maintenance Services emergency maintenance situations, etc.

Facility Manager, GSO-FM

D. Shipping - Discuss status of incoming, UAB, HHE, and vehicle shipments.

Hyon, Hae Kyun/Shipping

E. Vehicle Registration - Discuss insurance requirements for vehicles; obtain documents for completion.

Park, Chong Hwang/GSO-MT

X. PUBLIC AFFAIRS SECTION (GSO/PA COMPOUND)

Meet Deputy Public Affairs Officer - Introduction of Public Affairs office (ext. 4777)

DPAO

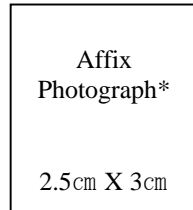
PLEASE RETURN TO HUMAN RESOURCES OFFICE AFTER COMPLETION.

APPLICATION FOR IDENTIFICATION CARD

Please read instructions given on reverse side for items with an asterisk(*) and complete this form in typescript.

This application should be sent by a note verbale together with two more photographs, one signature slip and photocopy of passport.

Application for { DIPLOMATIC ()
CONSULAR ()
SPECIAL () } Identification Card



Date of Application :

1. Full Name : (Please capitalize family name)	
2. *Name on ID Card (if applicable) :	
3. Date of Birth (mo./day/yr.) : / /	4. Place of Birth :
5. Nationality :	6. Sex :
7. Passport Type :	8. Passport Number :
9. Name of Mission :	
10. Office Address :	Telephone
11. *Title or Position :	
12. Date of Arrival (mo./day/yr.) : / /	13. Entry on Duty Date (mo./day/yr.) : / /
14. Residence Address :	Telephone
15. Accompanying Family Members : See Reverse Side	17. *Signature of Applicant
16. Curriculum Vitae : See Reverse Side	

<p>I certify that the photograph and the signature on this application are authentic. I undertake to ensure the return of the identification card to the Ministry of Foreign Affairs and Trade when the bearer's assignment in Korea is terminated.</p> <p>(Typed name and signature of Head/Acting Head of Mission)</p> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 10px;"></div>	<p><u>For Ministry Use Only</u></p> <p>신분증번호 : 직 위 : 특 기 사 항 :</p> <div style="margin-top: 20px;"> <table border="1" style="float: right; border-collapse: collapse;"> <tr> <td style="padding: 5px;">주무자</td> <td style="padding: 5px;">전산처리</td> </tr> <tr> <td style="height: 40px;"></td> <td style="height: 40px;"></td> </tr> </table> </div>	주무자	전산처리		
주무자	전산처리				

15. Accompanying Family Members

Name	Date of Birth (mo./day/yr.)	Sex (M.F)	Relationship

16. *Curriculum Vitae***Photograph :**

This application should be accompanied by two more photographs (25mm X 30mm) from the same negative taken within the past twelve months. Print name on the back of each photograph.

*** 2. Name on ID Card :**

If your full name contains more than 19 characters, please show how you want your name printed on the ID card using up to 19 characters (spaces and marks included).

***11. Title or Position**

Enter diplomatic/consular title including functional designation, if any. If no title, give position. If the applicant is a family member, specify the relationship to the official. (e.g., wife of First Secretary)

***16. Curriculum Vitae**

Please state the applicant's educational and professional background in detail. A separate curriculum vitae may be attached, if necessary.

***17. Signature of Applicant :**

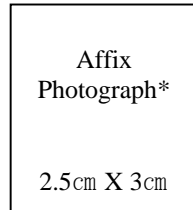
The signature must be identical with those on the signature slip.

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 DIPLOMATIC ()
 CONSULAR ()
 SPECIAL ()} Identification Card



Date of Application :

1. Full Name : (Please capitalize family name)	
2. *Name on ID Card (if applicable) :	
3. Date of Birth (mo./day/yr.) : / /	4. Place of Birth :
5. Nationality :	6. Sex :
7. Passport Type :	8. Passport Number :
9. Name of Mission :	
10. Office Address :	Telephone
11.*Title or Position :	
12. Date of Arrival (mo./day/yr.) : / /	13. Entry on Duty Date (mo./day/yr.) : / /
14. Residence Address :	Telephone
15. Accompanying Family Members : See Reverse Side	17. *Signature of Applicant
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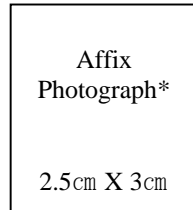
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Date of Application :

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5. Nationality :	6. Sex :
7. Passport Type :	8. Passport Number :
9. Name of Mission :	
10. Office Address :	Telephone
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12. Date of Arrival (mo./day/yr.) : / /	13. Entry on Duty Date (mo./day/yr.) : / /
14. Residence Address :	Telephone
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***16. Curriculum Vitae**

Please state the applicant's educational and professional background in detail. A separate curriculum vitae may be attached, if necessary.

***17. Signature of Applicant :**

The signature must be identical with those on the signature slip.

Embassy Form No. 2 (revised 10/17/95)
(Please type or print)

Application for Korean Operator's Permit

Name in Full:

Social Security No:

Arrival Date in Korea:

Date of Birth:

License No:

State of Issue:

Date of Issue:

Expiration Date:

Grade/Rank or
Diplomatic Title:

Passport No:

Organization: American Embassy Seoul

Telephone No:

Applicant's Signature

Date

Note: Please attach two (2) stamp-size (1-1/4 x 1") color photographs and state side driver's license (original) to this form.

Fee: 5,000 won

Embassy Form No. 2 (revised 10/17/95)
(Please type or print)

Application for Korean Operator's Permit

Name in Full:

Social Security No:

Arrival Date in Korea:

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License No:

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Grade/Rank or
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Telephone No:

Applicant's Signature

Date

Note: Please attach two (2) stamp-size (1-1/4 x 1") color photographs and state side driver's license (original) to this form.

Fee: 5,000 won



U.S. Department of State

FOREIGN SERVICE EMERGENCY LOCATOR INFORMATION

AUTHORITY: 2 FAM SECTION 190

PRINT EMPLOYEE NAME (<i>Last, First, MI</i>)	SSN	DATE (<i>mm-dd-yyyy</i>)
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EMPLOYEE LOCATION (Post, Base, Region, etc.)	AGENCY
AMERICAN EMBASSY, SEOUL, UNIT 15550, APO AP 96205-5550	

NAMES OF ELIGIBLE FAMILY MEMBERS	SSN	ADDRESS IF DIFFERENT THAN EMPLOYEE	RELATIONSHIP	PHONE

LIST BELOW CONTACTS FOR EMERGENCY PURPOSES

NAME OF CONTACTS FOR EMPLOYEE	ADDRESS (<i>Incl. ZIP code, List business address and phone for one.</i>)	RELATIONSHIP	PHONE
1.			
2.			
3.			
4.			
5.			
6.			

NAME OF CONTACT FOR SPOUSE	ADDRESS	RELATIONSHIP	PHONE
1.			

NAME OF SPOUSE (<i>If wife, give maiden name</i>)	SSN	HOMETOWN (Spouse)
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REMARKS

PRIVACY ACT STATEMENT

Uses: For notification of next-of-kin in the event of an emergency or death of an employee. Information available on a need-to-know basis to personnel of the Department as required in the performance of official duties. Failure to provide the information required will result in delay or suspension of notification of next-of-kin in the event of an emergency or death of employee.

ORIGINAL COPY

FOREIGN ALLOWANCES APPLICATION, GRANT AND REPORT				INTERAGENCY REPORT CONTROL NUMBER 1170-DOS-AN		VOUCHER NUMBER	
1. EMPLOYEE NAME <i>(Last, First, Middle Initial)</i>				2. SOCIAL SECURITY NUMBER			
3. AGENCY				4. AUTHORIZATION/GRANT NUMBER			
5. PAY PLAN/SERIES/GRADE/ANNUAL SALARY				6. POSITION TITLE			
7. CURRENT POST/COUNTRY OF ASSIGNMENT/LOCALITY			8. DATE OF ARRIVAL <i>(mm-dd-yyyy)</i>		9. PREVIOUS POST OF ASSIGNMENT		
10. MAILING ADDRESS							
11. IF LOCAL HIRE: DATE <i>(mm-dd-yyyy)</i> OF ARRIVAL AT POST/REASON FOR PRESENCE							
12. IF SPOUSE IS EMPLOYED BY THE US GOVERNMENT: NAME/SOCIAL SECURITY NUMBER/ALLOWANCES RECEIVED							
13. FAMILY DOMICILED AT POST							
NAME OF RELATIVE		RELATIONSHIP	DOB EXCEPT SPOUSE <i>(mm-dd-yyyy)</i>	% SUPPORT	DATE OF ARRIVAL AT POST <i>(mm-dd-yyyy)</i>	RESIDENCE ADDRESS	
14. FAMILY DOMICILED AWAY FROM POST							
NAME OF RELATIVE		RELATIONSHIP	DOB EXCEPT SPOUSE <i>(mm-dd-yyyy)</i>	% SUPPORT	DATE OF DEPARTURE FROM POST <i>(mm-dd-yyyy)</i>	RESIDENCE ADDRESS	
15. REMARKS							
Privacy Act Statement: Solicitation of this information is authorized under 5 U.S.C. 5922, E.O. 9397 and E.O. 10903, Section 1(b-2) and DSSR Section 073.4. The information is used to determine employee eligibility for and appropriate amounts of allowances. All forms are subject to fiscal audit by the employee's parent agency and GAO. The Office of Allowances, U.S. Department of State, will review forms to set LQA rates. Lack of requested information may result in erroneous or unauthorized allowances.							

FOREIGN ALLOWANCES APPLICATION, GRANT AND REPORT			VOUCHER NUMBER
16. EMPLOYEE NAME <i>(Last, First, Middle Initial)</i>			17. SOCIAL SECURITY NUMBER
18a. PAYMENTS/ENTITLEMENTS <i>[Check box(es). For calculations see DSSR chapter exhibits.]</i>			FOR OFFICIAL USE ONLY
TQSA - TEMPORARY QUARTERS SUBSISTENCE ALLOWANCE - (DSSR 120)			
Advance	Beg. Date <i>(mm-dd-yyyy)</i>	End Date <i>(mm-dd-yyyy)</i>	
Biweekly	Beg. Date <i>(mm-dd-yyyy)</i>	End Date <i>(mm-dd-yyyy)</i>	
Lump Sum <i>(upon completion)</i>	Beg. Date <i>(mm-dd-yyyy)</i>	End Date <i>(mm-dd-yyyy)</i>	
LQA - LIVING QUARTERS ALLOWANCE - (DSSR 130)		U.S. Dollar Payment _____ Foreign Currency Payment _____	
PA - POST ALLOWANCE - (DSSR 220)			
TRANSFER ALLOWANCE: FOREIGN (DSSR 240) [] <i>or</i> HOME SERVICE (DSSR 250) []			
Portion(s): Subsistence [] Miscellaneous [] Wardrobe [] Lease Penalty []			
SMA - SEPARATE MAINTENANCE ALLOWANCE - (DSSR 260)			
Voluntary [] Involuntary [] <i>(For convenience of U.S. government)</i>			
TSMA - TRANSITIONAL SEPARATE MAINTENANCE ALLOWANCE - (DSSR 260)			
Unaccompanied Post [] Completion of School Semester []			
EDUCATION: ALLOWANCE (DSSR 270) [] <i>or</i> TRAVEL (DSSR 280) []			
PD - POST DIFFERENTIAL - (DSSR 500)			
DP - DANGER PAY - (DSSR 650) 652f [] <i>or</i> 652g []			
Total Amount Claimed			
18b. ADVANCES			
LQA	Beg. Date _____	End Date <i>(mm-dd-yyyy)</i> _____	# of Months _____
U.S. Dollar Payment _____		Foreign Currency Payment _____	
TRANSFER ALLOWANCE: Foreign [] <i>or</i> Home Service []			
Portion(s): Subsistence [] Miscellaneous [] Wardrobe [] Lease Penalty []			
ADVANCE OF PAY (DSSR 850) This advance will be repaid in _____ pay periods.			
Travel Authorization <i>or</i>			
Permanent Change of Station (PCS) Number			
Name of Issuing Activity			
METHOD OF PAYMENT			
19a. If Electronic Funds Transfer (EFT) Mark one: [] Checking [] Savings			
FINANCIAL INSTITUTION NAME		FINANCIAL INSTITUTION MAILING ADDRESS	
ROUTING NUMBER		ACCOUNT NUMBER <i>(including any suffix)</i>	
19b. IF BY CHECK			
CHECK MAILING STREET ADDRESS			
CHECK MAILING CITY, STATE, ZIP CODE			
20. ACCOUNTING CLASSIFICATION(S):			
<p>21. Employee Statement and Signature: The information given on this application is true and correct to the best of my knowledge and belief. I also understand that I am obligated to notify the authorizing office immediately of any change in conditions which may affect the amount of allowances and/or differential authorized herein. I also understand that false statements made to the United States on this form may subject me to criminal penalties (including fines and imprisonment) under 18 U.S.C. 287 and 1001 and/or civil penalties under 31 U.S.C. 3729 or administrative penalties under 31 U.S.C. 3802. I understand if my employment is terminated prior to liquidation of any of these advances, any outstanding amount is due and payable immediately.</p>			
EMPLOYEE'S SIGNATURE: _____			DATE: <i>(mm-dd-yyyy)</i> _____
22. APPROVING/REVIEWING OFFICIAL SIGNATURE WHEN REQUIRED:			
_____			DATE: <i>(mm-dd-yyyy)</i> _____
23. CERTIFYING OFFICIAL: THE ABOVE REQUEST IS CERTIFIED AS CORRECT AND PROPER FOR PAYMENT			
AUTHORIZED CERTIFYING OFFICIAL'S SIGNATURE: _____			DATE: <i>(mm-dd-yyyy)</i> _____

* Items indicated by a Star are to be Completed by the Payee.	1. _____ <div style="text-align: center;"> (AGENCY) U.S. Department of State TRAVEL REIMBURSEMENT VOUCHER </div>					2. D.O. VOUCHER NO.					
					3. BU. VOU. NO.						
*4. PAYEE'S COMPLETE NAME AND ADDRESS					*5. TRAVEL AUTHORIZATION <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">A. Number</td> <td style="width:50%;">B. Dated (mm-dd-yyyy)</td> </tr> </table>			A. Number	B. Dated (mm-dd-yyyy)		
					A. Number	B. Dated (mm-dd-yyyy)					
6. D.O. PAID BY			*7. SOCIAL SECURITY NUMBER								
			*8. TRAVEL ADVANCE STATUS <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">A. Old Balance</td> <td style="width:50%;"></td> </tr> <tr> <td>B. Applied This Voucher</td> <td></td> </tr> <tr> <td>C. New Balance</td> <td></td> </tr> </table>			A. Old Balance		B. Applied This Voucher		C. New Balance	
			A. Old Balance								
			B. Applied This Voucher								
C. New Balance											
*9. OFFICIAL STATION (State Only)											
*10. STATEMENT OF GOVERNMENT-FURNISHED TRANSPORTATION					E. Point-to-Point Travel						
A. GTR or Vou. No	B. Valuation	C. Carrier*	D. Class	(1) from		(2) to					
*11. PAYEE CERTIFICATE: Certified Correct. Payment or credit has not been received. **					12. PAYMENT CALCULATION						
A. Date (mm-dd-yyyy)	B. Signature			*A. Amount Claimed (See Item 18.)							
13. ADMINISTRATIVE APPROVAL:				B. Differences, if any							
A. Date (mm-dd-yyyy)	B. Signature (See Item 8B.)			C. Amount Allowed (Verified correct to Appropriation)							
	Name: _____ Title: _____										
*14. PREVIOUS PAYMENTS: The next previous Vou. paid under same travel auth. was:				D. Applied to Advance (See Item 8B.)							
A. D.O. Vou. No.	B. Paid (mm-yyyy)	C.D.O. Name and Symbol									
15. CERTIFIED FOR PAYMENT: Pursuant to authority vested in me, I certify this voucher is correct and proper for payment:				E. Net to Payee							
A. Date (mm-dd-yyyy)	B. Authorized Certifying Officer's Signature										
	Name: _____ Title: _____										
16. METHOD OF PAYMENT (For Paying Office Use Only)											
A. Cash or Dep. Check Amt.	B. Exchange Rate	C. U.S. \$ Equivalent		*D. Date (mm-dd-yyyy)							
E. Treasury or Depository Check No. and Name of Depository				*F. Payment Received							
				_____ (Payee's Signature)							
17. ACCOUNTING CLASSIFICATION			D. Organization, Subcost, etc.	E. Function	F. Object, Resource, etc	G. Paying Office	H. Paying Date (mm-dd-yyyy)	I. Amount (State)			
A. Fund	B. Allotment	C. Oblig. (T/A) No.									

* Item 10C - If carrier was foreign ship registry, attach certificate of readiness.

** FRAUDULENT CLAIM - Falsification of any item in an expense account works a forfeiture of the claim (28 U.S.C. 2514) and may result in a fine of not more than \$10,000 or imprisonment for not more than 5 years or both (18 U.S.C. 287; i.d. 1001).

*18. CLAIM (Show complete itinerary and/or transportation expenses for persons and things for which reimbursement is claimed; on effects, show weights/measures and attach all receipts.)

REMARKS (Names of dependents including date of birth (DOB) of dependent children, explanation for use of foreign registry ship, rates of exchange, etc.)

Dates (mm-dd-yyyy) (A)	Local Time (B)	Itinerary and Description *(C)	Per Diem Days (D)	Daily Rate (E)	Amount	
					Per Diem (F)	Other (G)
GRAND TOTAL TO ITEM 12A ON FACE OF VOUCHER (Subtotals To Be Carried Forward)						

PRIVACY ACT STATEMENT Authority: E.O. 9397, dated November 22, 1943 and 5 U.S.C. 5705
Use of your social security number (SSN) is mandatory to process your application or claim. It is used in the mechanized travel advance data system, in addition to your name, as an identifier to assure crediting advances and reimbursements to the right person. Your providing your number will facilitate faster, more accurate processing. If you do not provide your SSN at this time, it must be researched manually with attendant delay, and with the possibility of errors if your claim is confused with that of another person having a similar name. Completed forms are subject to audit by the U.S. Department of State and General Accounting Office.

**LEAVE ACCOUNTING FOR AMERICAN EMPLOYEES
RETURNING FROM HOME LEAVE OR TRANSFERRING TO POST**

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	COUNTRY	POST	S/POST
		3 1 0	0 1	

PREVIOUS POST: _____
(If transferred from another post)

DATE OF DEPARTURE: _____
Month / Day / Year

DATE OF ARRIVAL: _____
Month / Day / Year

REPORT OF TIME DURING PERIOD OF TRAVEL

	DAYS or HOURS	INCLUSIVE DATES					
		From			To		
		mm	dd	yy	mm	dd	yy
HOME LEAVE (Days)							
HOME LEAVE (Days)							
HOME LEAVE (Days)							
HOME LEAVE (Days)							
ANNUAL LEAVE (Hours)							
SICK LEAVE (Hours)							
LWOP (Hours)							
COMP. TIME OFF (Hours)							
TRAVEL TIME (Days)							
TRAVEL TIME (Days)							
TRAVEL TIME (Days)							
TRAVEL TIME (Days)							
CONSULTATION (Days)							
TRAINING (Days)							
MILITARY LEAVE (Hours)							
OTHER ABSENCE (Hours)							
OTHER ABSENCE (Hours)							

EMPLOYEE SIGNATURE: _____ DATE: _____

CERTIFIED CORRECT BY: Michael J. Browning
(Admin / Personnel Officer)

TITLE: FMO DATE: _____



- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Section 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

A NAME OF PAYEE <i>(last, first, middle initial)</i>		D TYPE OF DEPOSIT OR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
ADDRESS <i>(street, route, P.O. Box, APO/FPO)</i>		E DEPOSIT OR ACCOUNT NUMBER <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	
CITY	STATE	ZIP Code	F TYPE OF PAYMENT <i>(Check only one)</i>
TELEPHONE NUMBER AREA CODE		<div> <div><input type="checkbox"/> Social Security</div> <div><input type="checkbox"/> Supplemental Security Income</div> <div><input type="checkbox"/> Railroad Retirement</div> <div><input type="checkbox"/> Civil Service Retirement (OPM)</div> <div><input type="checkbox"/> VA Compensation or Pension <div><input type="checkbox"/> Fed Salary/Mil. Civilian Pay</div> <div><input type="checkbox"/> Mil. Active _____</div> <div><input type="checkbox"/> Mil. Retire. _____</div> <div><input type="checkbox"/> Mil. Survivor _____</div> <div><input type="checkbox"/> Other _____</div> </div> </div>	
B NAME OF PERSON(S) ENTITLED TO PAYMENT		<i>(specify)</i>	
C CLAIM OR PAYROLL ID NUMBER		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY <i>(if applicable)</i>	
Prefix	Suffix	TYPE	AMOUNT
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		JOINT ACCOUNT HOLDERS' CERTIFICATION <i>(optional)</i> I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATED	SIGNATURE	DATE
SIGNATURE	DATED	SIGNATURE	DATE

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
------------------------	---------------------------

NAME AND ADDRESS OF FINANCIAL INSTITUTION		ROUTING NUMBER		CHECK DIGIT
		<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>		<div> <div></div> </div>
		DEPOSIT OR ACCOUNT TITLE		
<p align="center">FINANCIAL INSTITUTION CERTIFICATION</p> <p>I confirm the identity of the above-name payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.</p>				
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE		TELEPHONE NUMBER	DATE

FSC BANGKOK – ELECTRONIC FUND TRANSFER SIGN-UP

(To be used for travel reimbursement payments)

Directions: 1. Please type or print clearly in black ink.
2. Attach a voided blank personal check.

Name: (Last, first, middle) _____

Social Security Number: ____ - ____ - ____

Agency/Section: _____ Office Phone: _____

Embassy or Post: _____

Type of Deposit Account: ☐ Checking ☐ Savings

Account Number: _____

Name of Financial Institution: _____

Address: _____

Routing Number of Financial Institution:
(9 digit number on the lower left part of checks) _____

Certification:

In signing this form, I authorize my payment(s) to be sent directly via EFT to the Financial Institution named above for deposit into the designated account.

Signature of Account Holder

Date

(The Financial Service Center in Bangkok, Thailand (FSC Bangkok) cannot process this application without the proper signature.)

COMMAND UNIQUE PERSONNEL INFORMATION DATA SYSTEM APPLICATION (CUPI DS)

For Internal Use

Date Received by IA: _____

Date Received by JI: _____

SPONSOR INFORMATION FOR U.S. EMBASSY SEOUL

1. DEROS (estimated departure date from Korea): _____ 2. SECTION: _____

3. NAME: _____ 4. SSN: _____
(Last) (First) (MI)

5. REASON FOR SUBMISSION:

_____ I - New Arrival (Initial Issue) _____ A - Addition _____ D - Deletion

_____ E - Expire _____ F - Replace (Lost/Stolen) _____ O - Other

6. DOB (MMDDYYYY): _____ 7. GENDER (M/F): _____

8. CITIZENSHIP: _____ 1 - USA _____ 2 - ROK _____ 3 - Other

9. NUMBER OF DEPENDENTS WITH YOU IN ROK: _____

10. PHONE (if known): (Office) _____ (Home) _____

11. SERVICE (see below): _____ 12. SERVICE STATUS _____ 13. GRADE/PAY LEVEL: _____

Service - Choose From:

C-Civilian
A-Army
F-Air Force
N-Navy
M-Marine
O-Other
RN-Reserve Enlisted

EN-Enlisted
GS-General Schedule
NF-NAF Pay Grade
RE-Retired Enlisted
RO-Retired Officer
RF-Reserve Officer
RO-Reserve Warrant Officer

IC-Invited Contractor
OF-Officer
SA-OSI /CID Agent
WG-Wage Grade
WI-Widow
RW-Retired Warrant Officer
WO-Warrant Officer

Service Status - Choose From:

FE-Foreign Executive
FS-Foreign Service
FN-Foreign Service Enlisted
FO-Foreign Service Officer
FQ-Foreign Service Warrant Officer

14. SPONSORSHIP (Military Only): _____ C - Command Sponsor N - Noncommand Sponsor

Signature of Sponsor/Applicant

Signature/SSN of Validating Officer

15. UIC: EMBASSY Completed by Issuing Agent (IA) (IA Initials): _____

DATA REQUIRED BY PRIVACY ACT STATEMENT

1. **Authority:** 5 USC Section 301 and US/ROK Status of Forces Agreement.

2. **Principle Uses:** System of records used to identify individuals in support of noncombatant evacuation operations, controlling access to duty-free goods, and prevention detection of black marketing.

3. **Routine Uses:** This form is used as a source document for production of an RCP which is used for recording sales transactions. Sales information accumulated by SSN is available to commanders/law enforcement personnel for investigation of ration control violations and suspicious purchasing activities. This form is also used to enroll personnel and their dependents into the NEO database and for use in developing other personnel reports for the command.

4. **Mandatory or Voluntary Disclosure and Effect of Individual not Providing Information:** Ration control plates and accompanying privileges will not be provided if the SSN and accompanying data are not provided for use.

USFK FORM 42-E, 1 MAR 03

DEPENDENT INFORMATION

(Complete this Section for Dependents Residing with you in the ROK)

RELATIONSHIP CODE : W - Wife M - Mother/In-Law	H - Husband F - Father/In-Law	D - Daughter A - Other Male	S - Son B - Other Female
---	----------------------------------	--------------------------------	-----------------------------

Is Spouse Active Duty? _____ Yes _____ No

1. SPOUSE's SSN: _____ 2. SPOUSE's NAME: _____

3. RELATIONSHIP CODE (see above): _____ 4. DOB (MMDDYYYY): _____

5. CITIZENSHIP: _____ 1 - USA _____ 2 - ROK _____ 3 - Other 6. (For Internal Use Only: Issue RCP? _____ Yes _____ No)

7. NAME: _____ 8. SSN: _____

9. RELATIONSHIP CODE (see above): _____ 10. DOB (MMDDYYYY): _____

11. CITIZENSHIP: _____ 1 - USA _____ 2 - ROK _____ 3 - Other 12. (For Internal Use Only: Issue RCP? _____ Yes _____ No)

13. NAME: _____ 14. SSN: _____

15. RELATIONSHIP CODE (see above): _____ 16. DOB (MMDDYYYY): _____

17. CITIZENSHIP: _____ 1 - USA _____ 2 - ROK _____ 3 - Other 18. (For Internal Use Only: Issue RCP? _____ Yes _____ No)

19. NAME: _____ 20. SSN: _____

21. RELATIONSHIP CODE (see above): _____ 22. DOB (MMDDYYYY): _____

23. CITIZENSHIP: _____ 1 - USA _____ 2 - ROK _____ 3 - Other 24. (For Internal Use Only: Issue RCP? _____ Yes _____ No)

25. NAME: _____ 26. SSN: _____

27. RELATIONSHIP CODE (see above): _____ 28. DOB (MMDDYYYY): _____

29. CITIZENSHIP: _____ 1 - USA _____ 2 - ROK _____ 3 - Other 30. (For Internal Use Only: Issue RCP? _____ Yes _____ No)

FOR INTERNAL USE ONLY

RCP Number(s):	(1) _____	(4) _____
	(2) _____	(5) _____
	(3) _____	(6) _____

Signature of Issuing Agent

SSN of Issuing Agent

**121ST General Hospital
CHCS Registration Form**

PATIENT INFORMATION

Name : _____ PAT/CAT: _____ SSN: _____
 DOB: _____ Ethnic Origin: _____ Race: _____
 Sex: _____ Religion Preference: _____ Marital Status: _____
 Address: _____
 Home Phone: _____ Relation to Sponsor: _____
 Allergies: _____

SPONSOR INFORMATION

Sponsor Name: _____ PAT/CAT: _____ SSN: _____
 DOB: _____ Ethnic Origin: _____ Race: _____
 Sex: _____ Religion Preference: _____ Marital Status: _____
 Rank: _____ Lgth Service: _____ Fly Stat: _____ MOS: _____
 Unit: _____ Camp: _____
 Unit Address: _____
 City: _____ State: _____ Zip Code: _____
 Duty Phone: _____ DSN Phone: _____

EMERGENCY CONTACT INFORMATION - (Someone in Country/Supervisor)

Name: _____ Relationship: _____
 Address: _____
 Phone: _____

NEXT OF KIN - (Spouse, Parents, Brother, Sister, Grandparents, Aunts, Uncles, and Friends)

Name: _____ Relationship: _____
 Address: _____
 Phone: _____

OTHER DEPENDENTS - Place asterisks besides name if no record.

NAME	DOB	SSN	RELATION	ALLERGIES

This document may contain confidential information that is legally privileged under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations. If this correspondence contains healthcare information, it is being provided to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate civil and criminal sanctions. If you have received this correspondence in error, destroy any copies you have made and notify the sender or the chief of the Patient Administration Division, 121st Gen Hosp, at 737-8564. Access rights to this information are defined in AR 40-66 and DOD Regulation 6025.18, Health Information Privacy.

Client Medical Profile and "Check-in" Sheet

Please Print

Please complete a form for each member of the family at post. This information is medically Confidential and will be kept in your record in the Medical Unit. In case of medical emergency, medical evacuation, or hospitalization, the Medical Unit will have the necessary medical history and personal information available for you and your family.

Today's Date: _____

Seoul Assignment: Arrival Date: _____ Length of Tour: _____
Are you on TDY? Yes No If Yes, what is your departure date? _____
Are you a contract employee? Yes No

Patient's Name (Last, First, M): _____ Date of Birth: _____

Employee's name: _____ Employee's SSN: _____

Employee's Agency: _____ Home phone: _____

Interoffice Address: _____ Office phone: _____

Medical Information

Drug / Other Allergies: _____

Current Medications: _____

Chronic Health Problems: _____

Date of Last Clearance Exam: _____ Type of Medical Clearance: _____

Major Surgical Procedures: _____

Health Insurance: Name: _____ Enrollment Code: _____

ID: _____

Last 3 Overseas Duty Assignment and Dates: _____

Walking Blood bank

The Medical Unit requests your cooperation in maintaining current file for blood types. If you know your blood type and have an identification card, please indicate by circling the correct type.

Blood Type: A B AB O POS NEG

Would you be willing to donate blood to other U.S. Mission personnel? Yes No

Have you ever had Hepatitis? Yes No

Consent from Parent / Guardian for Minor Dependents

I/we hereby give permission and consent to the American Embassy Medical Staff to examine and treat _____ my dependent minor for emergency conditions in the event I/We are not available to accompany the child or out of the country.

Date: _____ Parent / Guardian: _____

Other Contract Person: _____ Phone: _____

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY STUDENT REGISTRATION

INSTRUCTIONS 1. Completed by Sponsor
2. Print (Ink) or type all entries.
3. Leave shaded areas blank.
4. See supplemental sheet for assistance.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 2164, 20 USC 921

PRINCIPAL PURPOSE(S): Required for enrollment of dependents into DoDEA Schools. Provides record of student and sponsor demographic data used in the administration of school programs. Provides emergency contact, pertinent medical and other vital information.

ROUTINE USE(S): Data is collected and entered into the automated School Information Management System for use by DoDEA personnel in providing educational and management programs. Release of student information to non-DoDEA personnel is restricted to U.S. Government personnel and other authorized individuals as approved by DoDEA. Sponsor information may be released to other schools, colleges, and prospective employers as part of the individual student record.

DISCLOSURE: Voluntary. Disclosure of the Social Security Number will expedite the registration process.

SECTION I – STUDENT INFORMATION

1a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

2a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

3a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

SECTION II – SPONSOR INFORMATION

4. Sponsor's Name (Last, First, Middle Initial)		5. Sponsor SSN/Unique ID	6. Pay/Civ Grade	7. Title / Rank
8. Organization		9. Location of Unit	10. Duty Phone	11. Rotation / ETS Date
12. Spouse's Name (Last, First, Middle Initial)	13. Spouse's Title	14. Spouse's Employer		15. Spouse's Duty Ph.
16. Mailing Address (e.g. APO/FPO) (If different from Physical)		17. Physical Quarters Address (Street, City, State, Zip Code)		
18. Sponsor Cell Phone	19. Spouse Cell Phone	20. Email Address		
21. Pager Number	22. Reserved	23. Local Use		

SECTION III – LOCAL EMERGENCY CONTACT INFORMATION

24a. Emergency Contact Name (Not Sponsor or Spouse)	24b. Contact Duty Phone	24c. Contact Home Phone
24d. Emergency Contact Address (During Day)	24e. Doctor's Name (If not Military Clinic)	24f. Doctor's Phone Number
25a. Emergency Contact 2 Name (Optional)	25b. Contact 2 Duty Phone (Optional)	25c. Contact 2 Home Phone
25d. Emergency Contact 2 Address (Optional)	25e. Local Use	

SECTION IV – PERMANENT STATESIDE / EMERGENCY CONTACT INFORMATION

26a. Contact Name	26b. Contact Home Phone
26c. Contact Address	26d. Relationship to Sponsor

SECTION V – CONSENT and SCHOOL USE INFORMATION

<p>I understand that I have the right to review my child(ren)'s records and that a copy of the school and health records will be released to the next school (exclusive of colleges and universities) he/she/they attend(s) without further approval.</p> <p>I give permission for my child(ren) to receive first aid at school and any emergency treatment considered necessary with the following exceptions noted below.</p> <p>I verify the information is correct or has been corrected.</p>		34. First Day Student Starts School (MMDDYYYY)	35. DoDAAC
		36. School Name	
		37. Orders on File / Verified	
		38. Birth Date Verified	
27. Exceptions (if none, enter NONE)		Y N	
		Y N	
28. Signature of Sponsor		39. Reserved	
		Y N	
29. Date (MMDDYYYY)	40. Registrar's Initials	41. Date (MMDDYYYY)	
30. Reserved	31. Reserved	42. Reserved	
32. Local Use	33. Local Use	43. Local Use	

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY STUDENT REGISTRATION

INSTRUCTIONS

1. Completed by Sponsor
2. Print (Ink) or type all entries.
3. Leave shaded areas blank.
4. See supplemental sheet for assistance.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 2164, 20 USC 921

PRINCIPAL PURPOSE(S): Required for enrollment of dependents into DoDEA Schools. Provides record of student and sponsor demographic data used in the administration of school programs. Provides emergency contact, pertinent medical and other vital information.

ROUTINE USE(S): Data is collected and entered into the automated School Information Management System for use by DoDEA personnel in providing educational and management programs. Release of student information to non-DoDEA personnel is restricted to U.S. Government personnel and other authorized individuals as approved by DoDEA. Sponsor information may be released to other schools, colleges, and prospective employers as part of the individual student record.

DISCLOSURE: Voluntary. Disclosure of the Social Security Number will expedite the registration process.

SECTION I – STUDENT INFORMATION

1a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

2a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

3a. Student Number	b. Student Legal Name (Last, First, Middle)		c. Preferred Name
d. Gender M F	e. Home Phone	f. Student SSN / Unique ID	g. Student Grade
h. Birth Date (MMDDYYYY)	i. Field Trip Permission Y N	j. Sponsor Relationship	k. Employer Type Code
l. Citizenship	m. Home Language Survey Completed Y N	n. Computer/Internet Permission Y N	o. Entry / Status Code
p. Student Email Address		q. Previous DoDEA Student ? Y N	r. Local Use

SECTION II – SPONSOR INFORMATION

4. Sponsor's Name (Last, First, Middle Initial)		5. Sponsor SSN/Unique ID	6. Pay/Civ Grade	7. Title / Rank
8. Organization		9. Location of Unit	10. Duty Phone	11. Rotation / ETS Date
12. Spouse's Name (Last, First, Middle Initial)	13. Spouse's Title	14. Spouse's Employer		15. Spouse's Duty Ph.
16. Mailing Address (e.g. APO/FPO) (If different from Physical)		17. Physical Quarters Address (Street, City, State, Zip Code)		
18. Sponsor Cell Phone	19. Spouse Cell Phone	20. Email Address		
21. Pager Number	22. Reserved	23. Local Use		

SECTION III – LOCAL EMERGENCY CONTACT INFORMATION

24a. Emergency Contact Name (Not Sponsor or Spouse)	24b. Contact Duty Phone	24c. Contact Home Phone
24d. Emergency Contact Address (During Day)	24e. Doctor's Name (If not Military Clinic)	24f. Doctor's Phone Number
25a. Emergency Contact 2 Name (Optional)	25b. Contact 2 Duty Phone (Optional)	25c. Contact 2 Home Phone
25d. Emergency Contact 2 Address (Optional)	25e. Local Use	

SECTION IV – PERMANENT STATESIDE / EMERGENCY CONTACT INFORMATION

26a. Contact Name	26b. Contact Home Phone
26c. Contact Address	26d. Relationship to Sponsor

SECTION V – CONSENT and SCHOOL USE INFORMATION

<p>I understand that I have the right to review my child(ren)'s records and that a copy of the school and health records will be released to the next school (exclusive of colleges and universities) he/she/they attend(s) without further approval.</p> <p>I give permission for my child(ren) to receive first aid at school and any emergency treatment considered necessary with the following exceptions noted below.</p> <p>I verify the information is correct or has been corrected.</p>		34. First Day Student Starts School (MMDDYYYY)	35. DoDAAC
		36. School Name	
		37. Orders on File / Verified	
		38. Birth Date Verified	
27. Exceptions (if none, enter NONE)		39. Reserved	
		40. Registrar's Initials	
28. Signature of Sponsor	29. Date (MMDDYYYY)	41. Date (MMDDYYYY)	
30. Reserved	31. Reserved	42. Reserved	
32. Local Use	33. Local Use	43. Local Use	

Department of Defense Education Activity Questionnaire for Race/Ethnicity and Home Language

Completion of this form is required for enrollment in DoD schools. The data collected is maintained for "Statistical Use Only" and is protected in accordance with the Privacy Act (93-579), OMB Circular A-108, and DoD Directive 5400.11. Unauthorized disclosure of this information constitutes a violation of the Privacy Act and may result in a fine up to \$ 5000.

Race/Ethnicity questions comply with OMB Standards for Maintaining, Collecting, and Presenting Data for Race and Ethnicity, dated 30 October 1997 (62 FR 58782-58790)

STUDENT NAME: _____

DATE: _____

PLEASE ANSWER ALL SECTIONS

ETHNICITY (Mark one)

_____ **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

_____ **NOT Hispanic or Latino.**

RACE (Mark one or more)

_____ **A – American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

_____ **B – Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **C – Black or African American.** A person having origins in any of the black racial groups of Africa.

_____ **E – White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

_____ **F – Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

HOME LANGUAGE SURVEY (Yes or No, and Mark Language)

Does an adult in the household speak a language other than English at home?

_____ Yes _____ No

Does the child you are registering speak a language other than English at home?

_____ Yes _____ No

What was the first language your child learned?

_____ English (E) _____ Another Language (A) _____ Both English & Another Language (B)

Language(s) Learned: _____

STUDENT ELIGIBILITY

To be completed by Sponsor. Please print or type.
(See Privacy Act Statement on reverse)

1. Student's Name (Last, First, MI)		2. Sex M F	3. Grade
4. Date of Birth (YY/MM/DD)	5. Sponsor's Name (Last, First, MI)		6. Rank
7. Sponsor's SSN	8. Sponsor's Organization and Location		
9. Duty Phone	10. Date of Rotation	11. Home Phone	

FOR DOD SPONSORS ONLY (MILITARY AND CIVILIAN)

1. Depns are: (circle one) Command / Non-command sponsored	2. Dependents were transported on U.S. Gov't funded travel orders Yes No
3. If civilian, entitled LQA? Yes No	4. If civilian local hire, work full-time? Yes No (Attach SF-50)
5. I have been advised of the DoD Dependents Schools commuting area. I understand that if family housing is obtained outside this area, transportation of dependent students between residence and nearest pickup point within the commuting area or to the school is the sponsor's responsibility.	

SPONSOR'S CERTIFICATION

I certify the above information is true. Should there be a change in my status, I will advise DoD Dependents Schools and provide required documentation.

If I pay tuition for my dependents, I understand the charges cover services currently available within the school. Any additional requirements for special needs or services will be separately charged.

Signature of Sponsor

Date

DO NOT WRITE IN THIS SPACE

(For school use only)

Date enrolled _____
(yr/mo/date)

Enrollment Category _____

Orders on file/verified: Yes ___ No ___ N/A ___

Entry Approval Received: Yes ___ No ___ N/A ___

Birthdate Verified: Yes ___ No ___ N/A ___

Verified by (Document):

Dependents verified by (Document):

School Name: _____

Registrar's Initials Date

SCHOOL HEALTH RECORD

Seoul American Elementary / Middle / High Schools

Student Name: _____ Grade: _____ SY 2004-2005

Date of Birth: _____

Circle the code(s) that applies to your child.

ALLERGIES

(What?)

ANIMALS _____
BEE STINGS _____
DRUGS _____

ENVIROMENTAL _____
FOOD _____
HAYFEVER _____
INSECT BITES _____
OTHER _____

CARDIOVASCULAR

SICKLE CELL ANEMIA
FREQUENT NOSEBLEED
HYPERTENSION
CONGESTIVE HEART DISEASE
RHEUMATIOD HEART
HEART MURMUR NO RESTRICTION
HEART MURMUR RESTRICTION
LEUKEMIA

DERMATOLOGY

ACNE
DERMATITIS
ECZEMA
MULTIPLE SKIN PROBLEMS
PSORIASIS

HEARING

MILD LOSS BOTH EARS
MILD LOSS LEFT EAR
MILD LOSS RIGHT EAR
MODERATE LOSS BOTH EARS
MODERATE LOSS LEFT EAR
MODERATE LOSS RIGHT EAR
SEVERE LOSS BOTH EARS
SEVERE LOSS LEFT EAR
SEVERE LOSS RIGHT EAR
AIDS BOTH EARS
AID LEFT EAR
AID RIGHT EAR
MULTIPLE HEARING PROBLEMS
OTHER HEARING PROBLEMS
CHRONIC OTITIS MEDIA
PE TUBES INSERTED

ENDOCRINE

DIABETES MELLITUS
GROWTH DISORDER
HYPOGLYCEMIA
HYPERTHYROID
HYPOTHYROID

VISION

WEARS CONTACTS
WEARS GLASSES
MULTIPLE EYE PROBLEMS
OTHER EYE PROBLEMS

GYN. URINARY GASTRO INTESTINAL

OTHER PROBLEMS _____
FREQUENT URINARY TRACT INFECTIONS
MULTIPLE GI PROBLEMS

MEDICATIONS

Does your child take any medications daily?

Yes _____ No _____

If yes, what medication(s)?

MUSCULOSKELETAL

OSTEOARTHRITIS
MUSCULAR DYSTROPHY
OSGOOD-SCHLATER SYNDROME
SCOLIOSIS

NEUROLOGY

CEREBRAL PALSY
HEADACHES
MIGRAINES
MULTIPLE NEURO PROBLEMS
OTHER NEURO PROBLEMS
SEIZURE DISORDER
HISTORY OF SEIZURE DISORDER

OTHER MEDICAL PROBLEMS

DENTAL PROBLEMS
NUTRITION DEFICIENCY
OBESITY

OTHER HEALTH CONDITIONS THE SCHOOL SHOULD KNOW ABOUT

PSYCHIATRIC DISORDERS

ATTENTION DEFICIT DISORDER
ANOREXIA
BULIMIA
DEPRESSION
OTHER PSYCHIATRIC PROBLEMS
MULTIPLE PSYCIATRIC PROBLEMS

RESPIRATORY DISORDERS

ASTHMA
BRONCHITIS
REACTIVE AIRWAY DISEASE

AUTHORITY: Title X, Section 133 7 1076,
Title V, Section 301.

PRINCIPAL PURPOSE: To record
pertinent data concerning student's
health.

ROUTINE USES: Data is collected and
entered into the automated School
Information Management System for use
by professional health and education
agencies.

MANDATORY/VOLUNTARY
DISCLOSURE / EFFECT OF NON-
DISCLOSURE: Voluntary. Without this
information school personnel will not be
able to provide appropriate education and
health services.

Parent's/Sponsor's Signature

Date

DSPA Form 120.1
Revised May 1999
Previous Editions Obsolete

DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS CERTIFICATE OF IMMUNIZATIONS

Students who enroll in DoD Dependent Schools (DoDDS) must meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. **This certification of immunization, completed by the local medical authority, must be provided to school officials at time of initial registration for placement in the official school records of the student.**

Name of Child

Date of Birth

Parent or Guardian

Instructions for Local Medical Authority: In the spaces provided, write the date (Mo/day/yr) of each immunization received. In the appropriate space write the date of the last TB screening and the reaction/mm reading.

Hepatitis B Vaccine: 3 doses: The 2nd dose should be given at least one month after the 1st dose. The 3rd dose should be given at least two months after the second and at least 4 months after the first.

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Diphtheria, Tetanus, and Pertussis Vaccine (Circle vaccine given.) 3 doses given singly or in combination, at least one of which was administered after the 4th birthday and the last one was given within 10 years (Td recommended at age 11-12 if more than 5 years have elapsed since the last DTaP/DPT/Td. Subsequent routine Td boosters are required every 10 yrs). * Pertussis vaccine is not required for individuals older than six (6) years of age.

DTaP, DTP, Td

DTaP, DTP, Td

DTaP, DTP, Td

DTaP, DTP, Td

DTaP, DTP, Td

DTaP, DTP, Td

DTaP, DTP, Td

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

HIB (Haemophilus influenza type b) 2 to 4 doses in infancy; 3 and 4 year olds with NO record of Hib in infancy only require ONE Dose. *Hib immunization is not required for individuals five (5) years of age or older.

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Polio Vaccine (Circle vaccine given.) 3 doses of Polio Vaccine (oral or injected), last one of which was administered after the 4th birthday.

IPV OPV

IPV OPV

IPV OPV

IPV OPV

IPV OPV

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

MMR (Measles, Mumps and Rubella): 2 doses of live attenuated vaccine given singly or in combination at least one of which was administered 28 days or more after the 1st dose, but 2nd dose recommended after the 4th birthday.

Mo/Day/Year

Mo/Day/Year

Mo/Day/Year

Varicella Vaccine: 1 dose of Varicella Vaccine through the age of 12 years, 2 doses for those 13 or older (at least one month apart), or reliable history of the disease.

DATE CHILD HAD DISEASE PER PARENT REPORT:

Mo/Day/Year

Mo/Day/Year

Mo/Year

Other: Specify Vaccine (not to include TB Skin Test)

Vaccine _____ Date _____ Vaccine _____ Date _____

PPD: Date: _____ Results: Negative ☐ Positive ☐ mm. Preventive Medicine Referral _____ BCG: Date: _____

I certify that the minimum immunization requirements have been completed, and or initiated. Immunizations are current until _____ when _____ immunization(s) is/are due.

Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for religious or medical reasons must be supported by official documents from church or medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived. Immunization(s): _____ Reason: _____ Waiver duration: _____

Signature and Stamp of Medical Authority/Date

DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS

SPECIAL NEEDS QUESTIONNAIRE

T:

STUDENT'S NAME _____ GRADE _____ Male ☐ Female ☐

Sponsor's Name _____ Phone: _____ / _____
Duty Home

COMPLETE ONLY THOSE SECTIONS WHICH DESCRIBE YOUR CHILD'S SPECIAL NEEDS

☐ My child has been in SPECIAL EDUCATION and has an Individualized Education Program (IEP) for:

☐ Learning Impairment/Disability

☐ Physical Impairment/ Other Health Impaired

☐ Communication Impairment

☐ Emotional Impairment

☐ Developmental Delay

(Please provide IEP and other records to school.)

☐ My child speaks LIMITED OR NO ENGLISH.

First language of Father: _____ Mother: _____

Languages spoken by the child: _____

Child's best language is: _____

Number of years child has attended English speaking schools: _____

☐ I give ☐ I do not give my permission for the school to screen my child's English ability.

☐ My child received help in a COMPENSATORY EDUCATION PROGRAM/ A 504 PLAN (non-special education academic assistance) for:

☐ Reading

☐ Math

☐ Language Arts

☐ My child was enrolled in a TALENTED AND GIFTED / HONORS PROGRAM.

Previous TAG/honors enrollment at: _____

Name of School and Location

☐ Test Scores Available

☐ Test Scores Not Available

☐ The school SHOULD BE AWARE OF THE FOLLOWING:

☐ Consider special seating in the classroom: for vision ☐ for hearing ☐

☐ Limited or no physical education because _____

☐ Counseling services need to be considered.

☐ My child was retained in _____ grade.

☐ Other needs or comments: _____

☐ I prefer to discuss my child's needs privately with the school counselor. Please call me.

☐ I am enrolled in the Exceptional Family Membership Program due to my child's educational needs

☐ My child does not have any special needs.

Sponsor's Signature _____

Date _____



Department of Defense Dependents Schools
Pacific Deputy Director's Office
Publicity Permission Form

Within the Department of Defense Pacific schools, there are many opportunities to celebrate the achievements and activities of our districts, schools, students, staff and community members. The Information Age has provided additional mediums to publish our accomplishments, showcase our educational programs and services, and strengthen two-way communication among our publics. While television and print publications have been traditional ways of getting information to our publics, we now have the added benefit of the Internet.

With regard to the Internet, DoDDS Pacific schools' official web sites follow the goals, guidelines and policies for responsible and safe Internet publication practices set forth by the Deputy Secretary of Defense and the DoDEA Web Publishing Guide.

In order for us to include a student, staff member or community member in print publications, television, multi-media or the Internet, permission is needed.

The following is provided for your review and signature:

I give permission for my child's name and/or image to be utilized in various media forms including: newsletters, DoDDS web sites (images only), DoDDS print and video productions, military community publications, military affiliated publications (Stars & Stripes), military affiliated electronic media (AFN/AFRTS), and public media (local, host nation, U.S. national newspapers, magazines, television).

Please indicate whether you approve or disapprove by signing below.

Printed Name of Child or Individual if for self

Approve _____

Signature of child's parent/guardian or individual if for self

Date

Disapprove _____

Signature of child's parent/guardian or individual if for self

SY '01-'02 _____

SY '02-'03 _____

SY '03-'04 _____

SY '04-'05 _____

This form is applicable for the current school year and will remain permanently in the student's file. Each subsequent year the student registers, the form is to be reviewed and updated by providing parent/guardian initials next to school year.

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY (DODEA) STUDENT COMPUTER AND INTERNET ACCESS AGREEMENT

PRIVACY ACT STATEMENT

Authority: DoD Directive 1342.6, DoD Dependents Schools; DoDDS System Notice 22

Principal Purpose(s): To permit an individual's use of government-owned computer resources in accordance with DoDEA policies governing use of the Internet and to permit enforcement of DoDEA policies governing access to computers and the Internet.

Routine Use(s): In accordance with DoD published routine uses.

Disclosure: Voluntary; however no individual is permitted to use DoDEA-controlled computer resources until they have signed this statement indicating agreement to use of such equipment in accordance with DoDEA Computer and Internet Access Policies.

I, _____, have completed the required classroom instruction,

(Student's Name - Please Print)

understand the Terms and Conditions on the reverse side of this document, and agree to adhere to the principles and procedures detailed within.

Should I breach the guidelines, I understand that I may lose all network privileges on the DoDEA network, school disciplinary and/or appropriate legal action may be taken.

Student's Signature

Date

(If you are under the age of 18 a parent or guardian must also read and sign this agreement.)

PARENT OR GUARDIAN

I, _____, have read the Terms and Conditions. I understand that
(Parent's or Guardian's Name - Please Print.)

network access is designed for educational purposes. DoDEA has taken precautions to eliminate controversial material. However, I also recognize it is impossible for DoDEA to restrict access to all controversial materials and I will not hold them responsible for materials acquired on the network. Further, I accept full responsibility for supervision if and when my child's use is not in a school setting.

I understand, consistent with DoDEA policy to protect individual privacy, my child's written and art work and his or her name may be published, but DoDEA does not authorize the use of photographs, home address, or home telephone number in association with my child's name. I also understand DoDEA does not authorize the use of the school's Internet service for commercial activity or personal use inconsistent with the Terms and Conditions.

I understand: (1) This form does not relinquish my child's rights in his or her work. (2) DoDEA is not responsible for subsequent copying or unauthorized use of the work by an outside person or agency. (3) The only personal identification of the work will be my child's name. (4) My child cannot be directly contacted through the page. All contact will go through the teacher.

Parent's Signature

Date

BOX OFFICE VIDEO RENTAL MEMBERSHIP APPLICATION

SSN	LAST NAME	FIRST NAME	HOME PHONE H W	DOB (DDMMYYYY)	
ADDRESS		CITY	STATE	ZIP	
FAMILY MEMBERS AUTHORIZED (AGES REQUIRED FOR CHILDREN UNDER 17)					
SPOUSE	DOB (DDMMYYYY)	NAME	DOB (DDMMYYYY)	NAME	DOB (DDMMYYYY)
NAME	DOB (DDMMYYYY)	NAME	DOB (DDMMYYYY)	NAME	DOB (DDMMYYYY)
AUTHORIZED MEMBERS (UNDER 17) FOR "R" RATED MATERIAL					
NAME		NAME		NAME	
MILITARY MEMBERS ONLY					
UNIT NAME	UNIT ADDRESS		CITY	STATE	ZIP
BRANCH OF SERVICE			DEROS	WORK PHONE	
TERMS AND CONDITIONS					

1. I agree to pay AAFES the replacement cost of any equipment, video games, tapes, or DVDs, which are lost, damaged or stolen while in my possession. I agree to pay an extended viewing fee for any equipment, video games, tapes or DVDs returned late. I understand that extended viewing fees will equal the rental fee per item for each day an item is returned late to a maximum of 15 days' rental fee per item.

2. Should equipment, games tapes, DVDs and/or extended viewing fees not be received within 15 days of the due date, I understand that my check cashing privileges will be suspended. After 25 days of the due date, the monies due AAFES will be charged to my Military Star account. If I do not have a Military Star account at this time, the amount will be subject to all collection costs, including administrative costs. Additionally, any delinquent debt is subject to collection under applicable federal law including, but not limited to Title 37, USC, Section 1007, and Title 31, USC, Section 3720.

3. I understand that any equipment, games, tapes or DVDs not returned within three days of the due date (3 days late) will result in a suspension of my rental privileges until all items are returned and all extended viewing fees are paid.

4. PRIVACY ACT OF 1974: Utilization of Social Security Number and personal information is authorized by Title 10, USC, Sections 3013, and 8013. Disclosure of my Social Security Number and personal information is voluntary; however, failure to provide it may result in refusal of service.

5. I hereby authorize the family members listed above to rent on my behalf, subject to the provisions cited above. This authority shall remain in effect until canceled by me in writing.

6. Customer is responsible for returning rental items to the specific AAFES Box Office Video store where it was rented.

SPONSOR/SPOUSE SIGNATURE _____ DATE _____



CATV Korea Region MWR CATV Sales Contract

<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Payroll Deduction	<input type="checkbox"/> Monthly Billing
Social Security Number		Rank / Civilian Grade	Branch of Service		
<input type="text"/>		<input type="text"/>		Method of Payment	
Last Name		First Name		*Army Personnel Mandatory Payroll Deduction	
<input type="text"/>		<input type="text"/>		\$ <input type="text"/>	
Local Mailing Address		Camp Location		Monthly Payment	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Stateside Permanent Address		Stateside Telephone #		Bldg.	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Home Telephone #		Work Telephone #		Room #	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
				Duty Unit	
				<input type="text"/>	
BILLING: Customer should make payment to: IMA-KORO-MWR, CATV Unit #15742 APO AP 96205-5742					

SERVICE STAFF ONLY			
<input type="text"/>		<input type="text"/>	
Service Center		Contract Forward Date YYMMDD	
<input type="text"/>		<input type="text"/>	
Converter No.1		Service Center Agent	
<input type="text"/>		<input type="text"/>	
Converter No.2		Converter No.3	
<input type="text"/>		<input type="text"/>	
Converter No.4		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
Initial:		Remote(s) _____ Cable(s) _____	

PRIVACY ACT STATEMENT: Used to apply for KORO MWR CATV subscription service. Information furnished may be disclosed to any DoD component or part thereof and, on request to other Federal, State or local Government agencies for official purposes.

IN WITNESS OF WHEREOF The parties hereto have executed this contract as of the day and year listed above and do accept the Conditions of Service as written. This does authorize Finance to initiate a U.S. Government payroll deduction on all U.S. Army active duty personnel.		Failure to notify KORO MWR CATV on change of DEROS/PCS may result in temporary disruption of CATV services or continuance of billing after DEROS/PCS.	
BY: <input type="text"/>		BY: <input type="text"/>	
MWR Sales Representative's Signature		Customer's Signature	

CONVERTER RETURN CREDIT

THIS CERTIFIES THAT ALL EQUIPMENT, CONVERTER(S) AND REMOTE(S), HAVE BEEN RETURNED AND PAYROLL DEDUCTION FOR CATV SERVICES WILL BE TERMINATED.

<input type="text"/>		<input type="text"/>	
MWR Sales Representative's Signature		Date YYMMDD	
<input type="text"/>		<input type="text"/>	
Forwarding Address:		Customer's Signature	
<input type="text"/>		<input type="text"/>	
Street Address		City	
<input type="text"/>		<input type="text"/>	
State		Zip	

EA FORM 875 Aug 03 (1) White - File Copy, (2) Yellow - SVC Center Copy, (3) Pink - Customer Copy

Joining the U.S. Embassy Association is easy!

Complete and drop off this form and fee (please see reverse for details) at the U.S. Embassy Association (Bldg 8105, South Post) or in the embassy interoffice mail. For more information, call 397-4487/7918-6124.

U.S. Embassy Association Membership Application

Name: (Last, First, M) _____

Current Position: _____ Office: _____

Mailing Address: _____

Alternate Mailing Address (if any): _____

Duty Phone Number: _____ Duty Fax Number: _____

Home Phone Number: _____ Email: _____

Expected Date of Departure from Korea: _____

FAMILY MEMBERS (Please use reverse side for additional names.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Applicant's Signature: _____ Date: _____

U.S. Embassy Association Membership Fee

Membership fee will be assessed one-time (per tour) for the sponsor and each eligible family member.

Sponsor: \$25.00

Each family member (all ages): \$5.00

This policy was approved by the U.S. Embassy Association Board of Directors on January 27, 2004, and will take effect March 14, 2004.